TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert B. Fraser, D.C.

Respondent Name
Insurance Company of the State of Pennsylvania

MFDR Tracking Number
M4-17-3654-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… we are disputing the decision made by the insurance of simply deleting our claim because no EOB was ever generated to give the provider a chance to appeal the carrier's decision."

Amount in Dispute: $2,340.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was originally reviewed on August 30, 2017 where it was denied because this workers' compensation claim has been denied. The bill was reviewed again but again the bill was denied because service rendered does not relate to an accepted compensable injury."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2016	Designated Doctor Examination, Functional Capacity Evaluation, and Work Status Form	$2,340.00	$1,908.25

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the requirements for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.225 sets out the fee guidelines for functional capacity examinations performed on or after September 1, 2016.
5. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work examinations performed on or after September 1, 2016.

6. 28 Texas Administrative Code §134.239 sets out the fee guidelines for work status reports provided in accordance with §134.240 and §134.250 on or after September 1, 2016.
7. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
8. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
9. The submitted documentation does not include explanations of benefits provided to the requestor prior to the request for medical fee dispute resolution.

Issues

1. Did the Insurance Company of the State of Pennsylvania take final action to pay, reduce, or deny the services in question?
2. Is Robert B. Fraser, D.C. entitled to reimbursement for the services in question?

Findings

1. According to Texas Labor Code Sec. 408.027(b), the Insurance Company of the State of Pennsylvania was required to pay, reduce, or deny the disputed services not later than the 45th day after it received the medical bill from Dr. Fraser. Corresponding 28 Texas Administrative Code §133.240(a) required the Insurance Company of the State of Pennsylvania to take **final action** by issuing an explanation of benefits not later than the statutorily-required 45th day. 28 Texas Administrative Code §133.2(6) defines final action as follows:

   Final action on a medical bill—
   (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or
   (B) denying a charge on the medical bill.

   Submitted documentation supports that Dr. Fraser submitted a bill for the services in question on September 22, 2016, by fax to the number provided by the insurance carrier on the Request for Designated Doctor Examination (DWC032). This evidence supports that the Insurance Company of the State of Pennsylvania received a medical bill for the services in question on or about September 22, 2016.

   According to Texas Labor Code Sec. 408.027(b), the Insurance Company of the State of Pennsylvania was required to pay, reduce, or deny the disputed services not later than the 45th day after it received the medical bill from Dr. Fraser. Corresponding 28 Texas Administrative Code §133.240(a) required the Insurance Company of the State of Pennsylvania to take **final action** by issuing an explanation of benefits not later than the statutorily-required 45th day.

   28 Texas Administrative Code §133.2(6) defines final action as follows:

   Final action on a medical bill—
   (C) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or
   (D) denying a charge on the medical bill.

   The Insurance Company of the State of Pennsylvania was not relieved of its requirement to pay, reduce, or deny the disputed services not later than the 45th day after it received the medical bill from Dr. Fraser, in accordance with Texas Labor Code Sec. 408.027(b). When the insurance carrier receives a medical bill, it is obligated to take the following actions pursuant to 28 Texas Administrative Code §133.240:

   (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill…**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill…
   (e) The insurance carrier **shall send the explanation of benefits** [emphasis added] in accordance with the elements required by §133.500 and §133.501 of this title…The explanation of benefits shall be sent to:
      (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill…

AIG argued in its position statement on behalf of the Insurance Company of the State of Pennsylvania, that "…it was denied because this workers' compensation claim has been denied. The bill was reviewed again but again the bill was denied because service rendered does not relate to an accepted compensable injury."

The Insurance Company of the State of Pennsylvania's failure to timely issue an explanation of benefits to Dr. Fraser creates a waiver of defenses that AIG raised in its response to medical fee dispute resolution under 28 Texas Administrative Code §133.307(d)(2)(F):

> The [carrier's] response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

Absent any evidence that the Insurance Company of the State of Pennsylvania raised any defenses that conform to the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the division concludes that the Insurance Company of the State of Pennsylvania failed to take final action to pay, reduce, or deny the services in question. Therefore, the services will be reviewed in accordance with applicable fee guidelines.

2. Dr. Fraser is seeking reimbursement of $2,340.00 for a designated doctor examination, functional capacity evaluation, and work status report performed on September 12, 2016.

   Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Fraser performed an evaluation of maximum medical improvement (MMI) as ordered by the division on request by the insurance company. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   Per 28 Texas Administrative Code §134.250(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that Dr. Fraser provided an impairment rating (IR), which included a musculoskeletal body part, and performed a full physical evaluation with range of motion for the lumbar spine, as ordered by the division on request of the insurance company. Therefore, the MAR for this examination is $300.00.

   28 Texas Administrative Code §134.250(4)(B) states:

   > When **multiple IRs** [emphasis added] are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

   Available documentation does not support that Dr. Fraser was ordered to address extent of injury. Therefore, multiple impairments were not required and documentation does not support that additional IRs were performed. No reimbursement is recommended for this service.

   Per 28 Texas Administrative Code §134.250:

   > The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is $500.00.

   Per 28 Texas Administrative Code §134.239, "When billing for a work status report **that is not conducted as a part of the examinations outlined in §134.240 and §134.250** [emphasis added] of this title, refer to §129.5

of this title." Therefore, the filing of the Work Status Report (DWC-073) is not separately payable when provided in conjunction with a designated doctor examination performed according to 28 Texas Administrative Code §134.240. No reimbursement is recommended for this service.

28 Texas Administrative Code §134.225 adopts the 28 Texas Administrative Code §134.203(c) MAR calculation by reference. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor (DWC CF). The DWC CF for 2016 is $56.82.

The geographic practice cost index (GPCI) for work is multiplied by the relative value (RVU) for work. The practice expense (PE) GPCI is multiplied by the PE RVU. The malpractice (MP) GPCI is multiplied by the MP RVU. The sum of the calculations is multiplied by the DWC CF.

The MAR for the service in question is calculated as follows:

For CPT code 97750-FC on September 12, 2016, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.00 is 0.45. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 0.92 is 0.4232. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.88964 is multiplied by the DWC CF of $56.82 for a total of $50.55. This total is multiplied by 15 units for a MAR of $758.25.

Texas Labor Code §408.027(h)(1) requires the insurance carrier to pay for a designated doctor examination "unless otherwise prohibited by this subtitle or by an order or rule of the commissioner." The division finds that the examination in question was not prohibited by the Texas Labor Code or by rule or order of the commissioner.

The total allowable for the services in question is $1,908.25. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,908.25.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,908.25, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.